

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00237/5

**TITLE:** Healthy Indiana Plan

**AWARDEE:** Indiana Family and Social Services Administration

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for Indiana’s Healthy Indiana Plan (HIP) section 1115(a) Medicaid demonstration (hereinafter referred to as “demonstration”). The parties to this agreement are the Indiana Family and Social Services Administration (“state”) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective January 16, 2013, unless otherwise specified. This demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Objectives
- III. General Program Requirements
- IV. Affected Populations and Populations Made Eligible under the Demonstration
- V. Hoosier Healthwise
- VI. Healthy Indiana Plan
- VII. General Reporting Requirements
- VIII. General Financial Requirements
- IX. Monitoring Budget Neutrality for the Demonstration
- X. Evaluation of the Demonstration
- XI. Schedule of State Deliverables during the Demonstration

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

This section 1115(a) demonstration provides authority for the state to offer two distinct health care coverage benefit packages to specified populations. The Hoosier Healthwise (HHW) Program supplements state plan benefits for Medicaid eligible children and those otherwise eligible adults who are not aged, blind or disabled. The HIP provides health care coverage for uninsured adults not otherwise eligible for Medicaid through a high deductible managed care health plan and an account styled like a health savings account called a Personal Wellness and Responsibility (POWER) Account. Separate from this demonstration, Indiana offers the Indiana Select Program which includes case management services to supplement state plan benefits

offered through Medicaid Select managed care programs for current Medicaid eligible adults who are aged, blind or disabled.

### *Hoosier Healthwise Program*

Indiana began the Hoosier Healthwise program in 1994, when it initially mandated managed care enrollment for all section 1931 children and adults through a waiver granted by the Secretary under the authority of section 1915(b) of the Social Security Act (the Act). By July 1997, the program was implemented statewide using a combination of managed care organizations (MCOs) and a Primary Care Case Management (PCCM) delivery system. Effective December 2005, all Hoosier Healthwise enrollees are served exclusively by MCOs.

Effective January 1, 2008, the authority for the Hoosier Healthwise program was provided solely through this demonstration.

### *Healthy Indiana Plan (HIP)*

The HIP provides a high-deductible health plan and an account styled like a health savings account called a POWER Account to uninsured adults including low-income custodial parents and caretaker relatives of Medicaid and Children's Health Insurance program (CHIP) children and uninsured non-custodial parents and childless adults. Participation in HIP is voluntary, but all enrollees will be required to receive medical care through the high deductible health plans and POWER Accounts. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the health plan will provide coverage for medical services up to an annual maximum amount. Eligible individuals who have certain high-risk conditions will be enrolled in the Enhanced Services Plan (ESP), a separate care delivery mechanism managed by the Indiana Comprehensive Health Insurance Association (ICHIA), the state's high-risk pool.

HIP offers the following coverage:

- 1) A basic commercial benefits package once annual medical costs exceed \$1,100;
- 2) A Personal Wellness and Responsibility (POWER) Account valued at \$1,100 per adult to pay for initial medical costs. The POWER Accounts provide incentives for participants to utilize services in a cost-efficient manner. HIP members make monthly contributions to their POWER Accounts depending on their income level; and
- 3) \$500 in "first dollar" preventive benefits at no cost to HIP members.

Under this demonstration, Indiana expects to achieve the following to promote the objectives of title XIX:

- Access: Ensure availability of necessary health services for Medicaid enrollees while offering health coverage to thousands of uninsured individuals;
- Prevention: Encourage individuals to stay healthy and seek preventive care;
- Personal Responsibility: Give individuals control of their health care decisions and incentivize positive health behaviors;
- Cost Transparency: Make individuals aware of the cost of health care services; and
- Quality: Encourage provision of quality medical services to all enrollees. Encourage quality, continuity, and appropriate medical care.

The following populations will participate in the Hoosier Healthwise (HHW) component of the demonstration. The three populations derive their eligibility through the Medicaid state plan.

- **HHW Population 1: HHW Caretakers.** HHW Caretakers include parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the state plan and resources less than or equal to \$1,000.
- **HHW Population 2: HHW Children.** HHW Children include all children eligible for Medicaid under the Medicaid state plan.
- **HHW Population 3: HHW Pregnant Women.** HHW Pregnant Women include pregnant women eligible under Medicaid up to and including 200 percent of the federal poverty level (FPL).

The following populations will participate in the HIP component of the demonstration:

- **Demonstration Population 4: HIP Caretakers.** HIP Caretakers include uninsured custodial parents and caretaker relatives of children eligible for Medicaid with family income up to and including the AFDC income limit specified in the state plan with resources in excess of \$1,000 who make POWER account contributions; and, uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family income above the AFDC income limit specified in the state plan through 200 percent of the FPL (no resource limit) who make POWER account contributions.
- **Demonstration Population 5: HIP Adults.** HIP Adults include uninsured non-custodial parents and childless adults (ages 19 through 64) who are not otherwise eligible for Medicaid or Medicare with family income up to and including 200 percent of the FPL (no resource limit) who make POWER account contributions.

### III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived

or identified as not applicable in the waiver and expenditure authority documents, of which these terms and conditions are part, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the time frames specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy statement affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon implementation of the change.
  - b. If mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The state shall not be required to submit title XIX state plan amendments (SPAs) for changes demonstration affecting any populations made eligible solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the state plan may be required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Demonstration Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a) An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment.
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX state plan amendment, if necessary; and
- d) If applicable, a description of how the evaluations design will be modified to incorporate the amendment provisions.

**8. Extension of the Demonstration.**

- a) States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 6 months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

- b) Compliance with Transparency Requirements 42 CFR Section 431.412:

Effective April 27, 2012, as part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 14 as well as include the following supporting documentation:

- i. Historical Narrative Summary of the demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed, and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information.

Where the STCs address any of the following areas, they need not be documented a second time.

- iii. **Waiver and Expenditure Authorities:** The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
  - iv. **Quality:** The state must provide summaries of External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
  - v. **Financial Data:** The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical, and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
  - vi. **Evaluation Report:** The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
  - vii. **Documentation of Public Notice 42 CFR section 431.408:** The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.
9. **Demonstration Phase-Out.** The state may suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out

plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS's approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b) **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
  - c) **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, state Health Official Letter #10-008.
  - d) **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- 10. CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration whenever it determines following a hearing, that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 11. Finding of Non-Compliance.** The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.
- 12. Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX.

CMS shall promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

In states with federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001, letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. section 431.408(b)(2)).

In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. section 431.408(b)(3)). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

#### **IV. AFFECTED POPULATIONS AND POPULATIONS MADE ELIGIBLE UNDER THE DEMONSTRATION**

16. **Populations.** This demonstration includes two distinct components. The following is an overview of eligibility for the two components, which are described in more detail in Tables 1 and 2.

- a. Under the HHW program, children, pregnant women and caretaker adults who are otherwise eligible under the state plan (with the exception of such adults who are eligible as aged, blind or disabled) receive state plan benefits and additional HHW benefits through comprehensive managed care organizations as described below.
- b. Under the HIP program, uninsured adults with and without children who have specified income and assets and are not otherwise eligible under the state plan or Medicare receive benefits through a high-deductible managed care health plan and, as a condition of eligibility, contribute to a POWER Account.

The mandatory and optional Medicaid state plan populations described below in Table 1 derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived.

Groups made eligible by virtue of the expenditure authorities expressly granted in this demonstration as described below in Table 2 are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as specifically waived or identified as not applicable to the expenditure authorities.

The eligibility criteria for this demonstration are outlined below. These tables are presented for information purposes and do not change the state plan requirements or otherwise establish policy.

**Table 1: Hoosier Healthwise Program Populations**

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
<b>State Plan Mandatory and Optional Groups</b>		
Pregnant women	0% FPL through 200% FPL; no resource limit	HHW Pregnant Women
Qualified Pregnant Women	Pregnant women up to the AFDC income limit for the particular family size as indicated in the state plan; resource limit of \$1,000	HHW Caretakers
Children under age 1	0% FPL through 200% FPL; no resource limit	HHW Children
Newborns born to & living with a woman who was eligible and received Medicaid on the date of the child's birth	Eligible for 1 year as long as mother is eligible for Medicaid or would be if pregnant <u>and</u> the child remains in the same household as mother.	HHW Children
Children 1 through 5	0% FPL through 133% FPL; no resource limit	HHW Children

Children 6 through 18	0% FPL through 100% FPL; no resource limit	HHW Children
Blind and Disabled children under age 18 receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan FPL; resource limit of \$1,000	HHW Children
Custodial parents and caretaker relatives of children eligible for Medicaid	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan; resource limit of \$1,000	HHW Caretakers
Blind and Disabled adults 18 years old and older receiving SSI and except for receipt of SSI would be eligible for AFDC	Income up to and including the AFDC income limit for the particular family size as indicated in the state plan; resource limit of \$1,000	HHW Caretakers

**Table 2: Healthy Indiana Plan (HIP) Program Populations**

<b>Description</b>	<b>FPL Level and/or other qualifying criteria</b>	<b>Demonstration Eligibility Group</b>
<b>Demonstration Eligible Groups</b>		
Custodial parents and caretaker relatives currently excluded from the Medicaid state plan who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income up to the AFDC income limit for the particular family size as indicated in the state Plan with resources in excess of \$1,000	HIP Caretakers
Custodial parents and caretaker relatives of children eligible for Medicaid or CHIP who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	Income above the AFDC income limit for the particular family size as indicated in the state Plan and up to and including 200% FPL; no resource limit.	HIP Caretakers
Non-custodial parents and childless adults (19-64) who do not meet the criteria of HIP Caretakers,	0% FPL through 200% FPL; no resource limit. At no point in time may the number of non-custodial parents and childless adults exceed	HIP Adults

Description	FPL Level and/or other qualifying criteria	Demonstration Eligibility Group
<b>Demonstration Eligible Groups</b>		
who have been uninsured for at least 6 months, and who are not otherwise eligible for Medicaid or Medicare	36,500.	

17. **Excluded Individuals.** Notwithstanding the eligibility criteria in paragraph 16, the following persons are excluded from the populations described above.

Hoosier Healthwise Program

- Persons eligible for Medicaid exclusively through categories other than those listed above in Table 2.
- Individuals eligible for Medicare.

Healthy Indiana Plan

- Individuals otherwise eligible for Medicare or Medicaid.
- Individuals who have access to an employer-sponsored health plan.
- Individuals who are currently enrolled in a health insurance program.

18. **Enrollment Cap for HIP Adults.** At no point in time may the number of noncustodial parents and childless adults enrolled in HIP exceed 36,500.

**V. HOOSIER HEALTHWISE**

19. **Benefits.** Benefits offered to HHW enrollees include all benefits available under the state plan and additional chronic disease management services. All benefits, with the exception of pharmacy, are delivered through a managed care delivery system. Effective January 1, 2010, pharmaceutical services are provided through a fee-for-service delivery system.

20. **Enrollment.** The state will continue to follow applicable federal law and regulations for determining eligibility for Medicaid and for enrolling those deemed eligible into MCOs, as well as policies and procedures that are described in the Medicaid state plan. The state may require members of the Medicaid eligibility groups described in paragraph 16 to enroll with an MCO as a condition for receiving medical assistance. The state may allow MCOs to assist enrollees in completing their applications for redeterminations; however, the state will be responsible for making the redetermination decision.

21. **Cost Sharing.** Any cost sharing requirements for HHW enrollees are stipulated in the Medicaid state plan.

## VI. HEALTHY INDIANA PLAN (HIP)

22. **General Description.** Individuals enrolled in HIP receive the benefits described in STC 30 and 31 through a high-deductible managed care health plan and an account styled like a health savings account called a POWER Account described in STC 35. All enrollees will receive covered services through one of two delivery systems described in STC 26 below. Enrollees must also make specified contributions to their POWER Accounts as a condition of continued enrollment. These accounts will be used by enrollees to pay for the cost of health care services until the deductible is reached; however, preventive services up to a maximum amount will be exempt from this requirement. Once the deductible has been met, the HIP MCO or Enhanced Services Plan (described below) will provide coverage for medical services up to an annual maximum amount.

The state provides benefits under the HIP using one of two delivery systems. For those enrollees who have an identified high-risk condition, benefits are rendered through the Enhanced Services Plan, a prepaid inpatient health plan (PIHP), operated by ICHIA, the same entity that manages the state's high risk pool. All other enrollees receive coverage through MCOs under contract to the state. The MCOs and ESP are subject to the federal laws and regulations as specified in 42 CFR Part 438.

In all cases, the enrollee is responsible for making contributions to a POWER Account.

### **Eligibility Determination, Enrollment, and Disenrollment**

23. **Enrollment.** Individuals may apply for HIP in one of two ways. Applicants may apply at Designated Enrollment Centers or directly at the Division of Family Resources (DFR) offices.

- a. **Application through Designated Enrollment Centers (DEC).** Individuals may complete an application through designated enrollment centers (such as hospitals, schools, community organizations, health clinics, etc.). The state will ensure that the DECs, as outstationed eligibility centers, comply with the regulations set forth at 42 CFR 435.904. The applicant may make an MCO selection at this time. As part of the application, a high-risk health questionnaire will also be required.

The DECs will forward complete applications, including all supporting documentation, to DFR within 35 days of the application's signature date, either online or via U.S. mail. DFR will make a final eligibility determination within 45 days of the signed application date. This 45-day period is inclusive of the 35 days the DEC has to forward the completed application to DFR.

- b. **Application through the Division of Family Resources (DFR).** The DFR will explain the HIP program and take an enrollee's application for the program. Individuals will also be able to apply for HIP online, over the phone, and by mail. The applicant may make an

MCO selection at the time they apply. As part of the application, a high-risk health questionnaire will also be required.

The applicant's application form will be checked for completeness through an automated process. If the application is not complete, DFR will contact the applicant to obtain the missing information. DFR will make a final eligibility determination within 45 days of the signed application date.

24. **MCO Information and Selection.** The state will contract with an enrollment broker to assist interested applicants with their MCO selection so they can make an informed decision. The enrollment broker will provide the applicant with appropriate counseling on the full spectrum of available MCO choices and will address any questions the applicant may have. Once an MCO has been selected, the enrollee is required to remain in that MCO for 12 months (coverage term), with limited exceptions specified in paragraph 27.

Individual family members may select different MCOs. If no family member receives coverage through ESP and no eligible family member has selected a plan, all eligible family members will be auto-assigned to the same MCO. If one of the family members receives coverage through ESP as described in paragraph 25, and no family member has selected a plan, all non-ESP family members will be auto-assigned to the same MCO.

25. **The Enhanced Services Plan for Individuals with High Risk Conditions.**

- a. If the high-risk health questionnaire completed at the time of application indicates that the applicant has one of the ESP-eligible conditions, the applicant will be enrolled by the state in the ESP. The state will determine which conditions are eligible for the ESP program on an annual basis and will identify these conditions in the MCO contracts. Some examples of conditions that are eligible for the ESP program include cancer, past recipient of organ and/or tissue transplants or awaiting an organ and/or tissue transplant, HIV/AIDS, aplastic anemia, or hemophilia. ESP is a PIHP that is managed by ICHIA, the organization that also manages the state's high risk pool. Persons enrolled in ESP will have access to the provider network maintained by ICHIA, and will be free to receive care from any ICHIA affiliated provider. The ESP specializes in managing populations with high-risk medical conditions. ESP members will receive disease and case-management services that will assist them in managing their health conditions.
- b. Demonstration eligibles assigned to ESP will be required to make monthly POWER Account contributions, with amounts determined on the same basis as for HIP MCO enrollees, following paragraphs 36 and 37. Indiana may elect either option (i) or (ii) below with respect to implementation of POWER Accounts for persons assigned to ESP. The state must include a report on which option it is currently using, and any plans to change the option, in each Quarterly Progress Report (as required under paragraph 53).
  - i. Indiana may elect to make state contributions to ESP enrollees' POWER Accounts, as described in paragraph 37. The state will require ESP to manage their enrollees' POWER Accounts, in conformity with paragraphs 38 through

46. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 30, once their annual deductible has been reached, as well as disease management services provided by ESP. The state will reimburse ESP for the cost of all services provided to an enrollee in excess of those defrayed through the enrollee's POWER Account.

Indiana may elect not to make state POWER Account contributions to ESP enrollees' POWER Accounts. In this case, ESP must collect the required monthly POWER Account contributions and will use these monies to defray the cost of services provided to ESP enrollees within the coverage term. Demonstration eligibles assigned to ESP will receive coverage for services listed in paragraph 34, as well as disease management services provided by ESP. The state will reimburse ESP for the cost of services provided to an enrollee beyond those defrayed by the enrollee's POWER Account contributions. If, during the course of a coverage term, an individual's medical claims do not exceed \$1,100 for the year, the enrollee's required contribution for the new year will be based on the POWER Account carry-forward procedures, as described in paragraph 36(c), and calculated as if the state had made a full POWER Account contribution as stipulated in paragraph 37(a).

- c. Demonstration eligibles assigned to ESP will not be considered to be enrolled in ICHIA, the state's high risk pool; ESP will provide only administrative services and access to the ICHIA provider network. ESP will also provide disease management services.
- d. If the high-risk condition was not disclosed on the high-risk health questionnaire or is not identified on the application, but is on the list ESP-eligible conditions, the MCO may refer an individual to the ESP Plan. The requirements governing the MCO's referral are outlined in the MCO contracts. In general, the MCO's referral must be supported by the documentation required by the state's referral criteria such as the appropriate physical examination, initial claims data, and/or physician questionnaire. In general, if the state does not receive the MCO's notification and/or request to transfer the enrollee to ESP within 180 days (or the time period denoted in the MCO contract), the enrollee will remain in the MCO for the rest of the coverage term. At the end of the coverage term, the MCO will have another opportunity to use prior claims data, a physician exam, or a physician questionnaire as determined by the state's referral criteria to transfer the enrollee to ESP. The MCOs will be subject to an audit of their transfers of HIP members to the ESP. The specifics of the audits and the penalties associated with the audits are outlined in the MCO contracts.
- e. At the time of redetermination, the state may transfer an enrollee from ESP to an MCO if the state or its designee determines that the enrollee does not have an ESP-eligible condition. The requirements governing how an ESP member could be transferred to an MCO are outlined in the MCO and ESP contracts. In general, if a member is not found to have an ESP-eligible condition, the member will be sent a notice informing the member that he or she will be transferring from the ESP to their MCO choice once the redetermination is completed. The notice will inform the member that the member may make a new plan choice.

The state will develop a process through which a HIP member may appeal the state's decision to move the member out of an MCO to ESP or out of ESP to an MCO. The state shall include a description of this process in the first Annual Report required in paragraph 53.

- 26. HIP Managed Care Organizations.** Any HIP participant who is not enrolled in the ESP shall be enrolled to receive service through an MCO. The HIP participant will be given an opportunity to select an MCO at the time of application. A HIP participant who does not make an MCO selection at the time of application may be auto-assigned to a HIP MCO by the state. Auto-assignment may occur after the date in which the state determined their eligibility, or 14 days after the application's signature date, whichever is later.

Auto-assignment will be done on a rotating basis to assure that applicants are assigned evenly among MCOs. The state may consider assignment to the lowest cost MCO, or to the MCOs that demonstrate strong health outcomes and quality health care services. Enrollees will be advised promptly of the auto-assignment and their right to change MCOs before the first POWER Account contribution is made.

**27. Enrollee's Right to Change MCOs.**

- a. At the beginning of their first coverage year, an enrollee may change HIP MCOs without cause within 60 days after initially choosing or being auto-assigned to a HIP MCO, or the date their HIP MCO received their first POWER Account contribution, whichever comes first.

The state shall notify HIP members 90 days before the end of their coverage term that they must apply for continued coverage. The state shall also notify HIP members that they may change plans without cause at the time they submit their application for a second or subsequent coverage term. Members may seek assistance from the enrollment broker in choosing an MCO.

- b. "Cause" is defined as "receiving poor quality care coverage," which includes, but is not limited to, the following:
- i. Failure of the Insurer to provide covered services;
  - ii. Failure of the Insurer to comply with established standards of medical care administration;
  - iii. Significant language or cultural barriers.
  - iv. Corrective Action levied against the Insurer by the Family and Social Services Administration (FSSA); or
  - v. Other circumstances determined by FSSA or its designee to constitute poor quality of health care coverage.
- c. The enrollee must submit his or her request for change to the enrollment broker either orally or in writing. The enrollment broker will assure that the enrollee has sought redress through the MCO's grievance system before referring the request to the state

for making a determination regarding the change request. The enrollee shall still have access to the state's normal grievance and appeals process required under the managed care regulations.

- d. If the state fails to make a determination by the first day of the second month following the month in which the enrollee files the request, the request for change will be considered approved and the enrollee will be transferred into the new MCO.
- e. If an enrollee is transferred from the MCO, the MCO must disable the enrollee's POWER Account card immediately, and return the remaining balance of the individual's POWER Account balance to the state within 30 days of the last date of participation with the MCO. The state will then provide the entire POWER Account balance to the new MCO with the information needed to properly track the individual's contribution.
- f. The state will ensure that all transferring individuals receive coverage from their new MCO promptly, without any interruption in coverage.

**28. Redetermination of Eligibility.** Redetermination of eligibility for HIP will occur at least once every 12 months. An enrollee may request a redetermination of eligibility for HIP due to a change in family size (e.g., death, divorce, birth, marriage, adoption) at any time, and the state must perform such redeterminations upon request. Requests for redetermination based on changes in income will be subject to a once a year qualifying event. A "qualifying event" is defined as a job loss or other event resulting in a change in income. Each redetermination must include a reassessment of the individual's eligibility for Medicaid, and may result in a reduction of the enrollee's required POWER Account contribution. The state may consider allowing more than one "qualifying event" a year on a case-by-case basis, if the HIP member experiences a job loss or other change in income that results in undue hardship. The enrollee's MCO may assist the enrollee in completing the steps necessary to remain eligible for HIP.

**29. Disenrollment from HIP unrelated to POWER Accounts.** The state may disenroll an enrollee from HIP for any of the following reasons:

- a. The enrollee is determined ineligible for HIP at redetermination;
- b. The enrollee obtains access to employer-sponsored coverage;
- c. The enrollee becomes covered under another health insurance policy or FSSA program;  
or
- d. The enrollee becomes pregnant. Upon pregnancy, the enrollee will become eligible for Hoosier Healthwise, and will be enrolled in that program.

- e. Should a participant be disenrolled from HIP for any of the reasons listed above, the HIP MCO must return any remaining POWER Account balances to the participant or the state as described in paragraph 44.

**Benefits**

30. **HIP Covered Benefits.** HIP covers physical, behavioral health and pharmacy services as specified below. All benefits are limited by medical necessity as defined by the state. This list of benefits specifies the minimum set of benefits available to HIP members.

**Table 3: Healthy Indiana Plan Benefits**

<b>Benefit</b>	<b>Limits</b>
<b><i>Inpatient Facility</i></b>	
Medical/Surgical	
Mental Health/Substance Abuse	Covered same as any other service
Skilled Nursing Facility	Subject to a 60-day maximum
<b><i>Outpatient Facility</i></b>	
Surgery	
Emergency Room	Co-payment for services determined to be non-emergency as specified in Section VI, paragraph 33(b)
Urgent Care	
Physical/Occupational/ Speech Therapy	25-visit annual maximum for each type of therapy
Radiology/Pathology	
Pharmacy and Blood	
Cardiovascular	
<b><i>Professional Services</i></b>	
Inpatient/Outpatient Surgery	
Inpatient/Outpatient/ ER Visits	
Office Visits/ Consults	
Preventive Services	At least \$500 annual first dollar coverage
Physical/Occupational/Speech Therapy	25-visit annual maximum for each therapy
Cardiovascular	
Radiology/Pathology	
Outpatient Mental Health/ Substance Abuse	Covered the same as any other illness
<b><i>Ancillary Services</i></b>	
Prescription Drug	Brand name drugs are not covered where a generic substitute is available.
Home Health (including hospice)/ Home IV Therapy	Excludes custodial care. Includes case management.

Ambulance	Emergency ambulance transportation only, subject to the prudent layperson's standard.
Durable Medical Equipment/Supplies/Prosthetics	
Family Planning Services	Excludes abortion or abortifacients. Includes contraceptives and sexually transmitted disease testing as described in Medicaid law (42 USC 1396).
Lead Screening Services	Ages 19 and 20 only
Hearing Aides	Ages 19 and 20 only
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services	Subject to the HIP benefit coverage limits
Disease Management Services	

### 31. Preventive Benefits.

- a. Enrollees will have an annual budget of at least \$500 for “first dollar coverage” to pay for preventive services. Enrollees may not be required to pay any cost sharing for the first \$500 of preventive services in any coverage year. The first \$500 in preventive care service will not count against the \$1,100 annual deductible and will not be accessed using the enrollee’s POWER Account card. Preventive services in excess of the “first dollar coverage,” are covered, but are subject to the deductible.
- b. For coverage terms beginning the first year of the demonstration, each enrollee is required to receive an annual physical by the end of their 12-month eligibility period. For subsequent years of the demonstration, each enrollee will be required to access the appropriate preventive services (defined as care that is provided to an individual to prevent disease, diagnose disease, or promote good health) for their specific age and gender as described in paragraph 31(c) below. These requirements are for purposes of the carry-forward of POWER Account funds described in paragraph 42(c).
- c. As part of the first Quarterly Progress Report (as required under paragraph 52), the state will submit a list of the services (including services codes) that are considered to be preventive services that can be provided from the \$500 of “first dollar coverage,” and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds described in paragraph 23(c). Any changes to these must be reported by the state in a subsequent Quarterly Progress Report. The current preventive services requirements to receive full carry-forward of POWER Account funds must be posted promptly to FSSA’s public Web site.

**32. Annual and Lifetime Benefit Limits.** The benefits available under HIP are limited to \$300,000 annually and \$1 million over a lifetime.

- a. If during a coverage term, an enrollee exceeds the annual benefit limit of \$300,000, the enrollee will remain enrolled in the MCO or ESP and must continue to make POWER Account contributions; however, the enrollee will not have access to covered services. After redetermination and at the beginning of a new coverage term, the enrollee will have reinstated access to covered services.
- b. If an enrollee exceeds the lifetime benefit limit of \$1 million, the enrollee will be disenrolled from HIP following the procedures specified in paragraph 45(c). If enrollees exceed \$200,000 in benefits in a year or \$900,000 in benefits in a lifetime, they must be informed that they may apply for Medicaid, Medicaid for Employees with Disabilities (M.E.D. Works), and/or ICHIA, the state’s high risk pool. Notices must be provided to ensure the enrollee has a reasonable time to provide the necessary documentation.

**Cost Sharing**

**33. Allowable HIP Cost Sharing**

- a. HIP enrollees may be subject to cost sharing only as described in (b) below. Neither the required monthly POWER Account contributions discussed in paragraph 35, nor payments made from the POWER Account to defray the cost of services prior to the deductible being reached, are considered cost sharing for this purpose.
- b. HIP enrollees may be charged co-payments for non-emergency use of a hospital emergency department, subject to the following conditions.
  - i. The maximum amounts that can be charged to HIP enrollees are as follows:

<b>Population</b>	<b>Co-Payment Amount</b>
HIP Caretakers With Incomes Above the AFDC Income Limit as Indicated in the state plan through 100% FPL	\$3 per visit
HIP Caretakers Above 100 % through 150% FPL	\$6 per visit
HIP Caretakers Above 150 % through 200% FPL	Lower of 20 percent of the cost of the services provided during the visit, or \$25
HIP Adults	\$25 per visit

- ii. The conditions stated in section 1916A(e)(1) of the Act and in the August 15, 2007, State Medicaid Directors Letter (SMDL) #07-010 must be met.

- iii. The individual must receive an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Labor Act, or EMTALA provision of the Act.
  - iv. Assuming the individual actually has an available and accessible alternate non-emergency services provider and a determination has been made that the individual does not have an emergency medical condition, the hospital must inform the individual before providing non-emergency services that:
    - The hospital may require payment of the above-named cost sharing before the service can be provided.
    - The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible.
    - An alternate provider can provide the services without the imposition of the state-specified higher cost sharing for the inappropriate use of the ER.
    - The hospital provides a referral to coordinate scheduling of this treatment.
  - v. The co-payment for HIP Caretakers must be refunded if the person is found to have an emergency condition, as defined in section 1867(e)(1)(A) of the Act, or if the person is admitted to the hospital on the same day as the visit. The co-payment for HIP Adults need not be refunded.
- c. For families that include HIP Caretakers, the total aggregate amount of POWER Account contributions, Medicaid and HIP cost sharing, and CHIP premiums and cost sharing may not exceed 5 percent of the family income of the family involved. Family income will be determined under the methodology applicable to the group under the state Medicaid plan. The state must develop a process for ensuring that families do not exceed the 5 percent cost sharing limit, and must include a description of this process in the first Annual Report required in paragraph 53.

### **HIP POWER Accounts**

**34. General Description.** The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and will, at a minimum, be funded with state, federal, and enrollee contributions. Employers may contribute as well, with some restrictions.

POWER Accounts are designed to encourage preventive care, the appropriate utilization of health care services and personal responsibility. Enrollees will be informed that responsible use of POWER Account funds, as well as utilization of recommended preventive care services, can lead to a reduced financial burden in the subsequent years. If enrollees are aware that prudent management of their health care expenditures can leave them with available funds at the end of the year—and that these funds can be used to lower the following year’s contribution—enrollees will be encouraged to make value- and cost-conscious decisions.

Enrollees will make the same POWER Account contribution regardless of the delivery system under which they receive benefits. The amount of annual POWER Account

contributions is based on family size and income. Family income will be determined under the methodology applicable to the group under the state Medicaid plan. The enrollee’s coverage will begin on the first of the month after his or her first POWER Account contribution is received and processed.

Therefore, individuals eligible for HIP are deemed “conditionally eligible” until they make their first POWER Account contribution. Eligibility does not become final until the individual has made their first POWER Account contribution and, if the payment is made by check, the check clears to the MCO or ESP.

**35. Required Enrollee Participation in a POWER Account.** HIP enrollees are required to help fund the \$1,100 deductible by contributing to a POWER Account. Contributions will be determined on a sliding scale based on the enrollee’s family income, so that POWER account contributions when added to other payments made by the enrollee’s family to CHIP, Medicaid or Hoosier Healthwise will not exceed 5 percent of an enrollee’s gross annual family income. Enrollee contributions will be reduced by the amounts of employer or non-profit contributions made to the POWER account on behalf of the enrollee.

a. The sliding scale for POWER Account contributions is as follows:

**Table 4 – POWER Account Contributions**

<b>Annual Household Income</b>	<b>Maximum POWER Account Contribution</b>
All enrollees at or below 100 percent FPL	No more than 2 percent of income
All enrollees above 100 through 125 percent FPL	No more than 3 percent of income
All enrollees above 125 through 150 percent FPL	No more than 4 percent of income
HIP Caretakers above 150 through 200 percent FPL	No more than 4.5 percent of income
HIP Adults above 150 through 200 percent FPL	No more than 5 percent of income

b. The state will develop an algorithm to determine the amount of an enrollee’s annual required contribution and will notify the MCO and ESP of this amount. The MCO and ESP must bill for, and collect, the required enrollee contribution.

c. Enrollees must be given the opportunity to pay their required contribution in equal monthly installments.

**36. Enrollee POWER Account Contributions.** The state will notify new enrollees of POWER Account contribution requirements at the same time the state informs new enrollees that they have been found “conditionally eligible.”

a. **Initial Enrollee Contribution.** The first installment will be due 60 days after the enrollee is enrolled into an MCO or ESP, and may not exceed one-twelfth (1/12) of the enrollee’s total required annual POWER Account contribution. HIP coverage will not begin until the first day of the coverage month after the first POWER Account contribution installment is received, or, if payment is made by check, the check clears.

The MCO or ESP must notify the state within 5 to 30 days after an enrollee's first POWER Account contribution installment has been received.

- b. **Ongoing Monthly POWER Account Contributions.** In families with two enrolled individuals, each enrollee will have their own POWER Account. However, the total of both enrollees' POWER Account contributions cannot exceed the total POWER Account contribution that applies to the family's annual household income as specified in paragraph 35(a).
- c. **Recalculation of Enrollee POWER Account Contribution Amount.** At the end of each coverage term and after the enrollee has been determined eligible for another coverage term, the enrollee's POWER Account contribution may need to be recalculated for the new coverage term, based on changes in the enrollee's annual household income identified at the time of redetermination.

The state will notify the MCO or ESP of the enrollee's POWER Account contribution for the new coverage term, and within 60 days, the MCO or ESP will:

- i. Reduce the enrollee's POWER Account contribution for the new coverage term by the amount of the enrollee's POWER Account balance that was carried forward as calculated in paragraph 42(c);
- ii. Notify the enrollee of this roll-over amount, as well as the new amount to be billed to the enrollee in equal monthly installments in the new coverage term; and
- iii. Reconcile any overpayments or underpayments made by the enrollee as a result of the overlapping timeframes of monthly payments and recalculation of new contribution amounts for the new coverage term.

**37. State POWER Account Contributions.**

- a. The state will fund any gap between a non-ESP enrollee's annual required POWER Account contribution and the \$1,100 deductible. The state will make its entire contribution to the POWER Account promptly after receiving notice from the MCO that the enrollee's first POWER Account contribution has been received and processed.
- b. The state may choose whether or not to fund the gap between an ESP enrollee's annual required POWER Account contribution and the \$1,100 deductible, following requirements addressed in paragraph 25.

**38. "Up -Front" POWER Account Contribution by MCO or ESP.**

- a. In the case where a covered service may exceed the member's current POWER Account balance, the MCO or ESP must reimburse the provider for the balance according to its normal claims processing procedures. The MCO or ESP can recover the funds it paid on the member's behalf with future POWER Account contributions paid by the member.

- b. If an enrollee is terminated under the provisions in paragraphs 43 and 45 before the full annual POWER Account contribution is paid to the MCO or ESP, the MCO or ESP will levy the enrollee's account and notify the state of the enrollee's debt.
- c. The MCO or ESP may attempt to collect the unpaid POWER Account contributions from the enrollee, including reporting the debt to credit reporting agencies. However, the MCO or ESP may not "sell" the debt for collection by a third-party.
- d. If the enrollee should reapply for HIP, after the mandatory 12-month waiting period specified in paragraphs 42 and 44, the enrollee must pay the prior POWER Account debt as well as the first month's contribution before services can begin.

39. **Employer Contributions.** Employers are permitted and encouraged to contribute to their employees' POWER Accounts. An employer's contribution must be used to offset the employee's required contribution only—not the state's.

40. **Not-for-Profit Contributions.** Not-for-profit organizations are permitted to contribute up to 75 percent of an enrollee's POWER Account contribution. A not-for-profit organization's contribution must be used to offset the enrollee's required contribution only—not the state's.

41. **POWER Account Card.** The MCO or ESP must issue a card to each enrollee promptly after processing the enrollee's first POWER Account contribution, within thirty (30) days. This card may have all POWER Account contributions loaded onto it.

- a. An electronic account update will be e-mailed to the enrollee by the MCO or ESP each time a contribution is credited to the enrollee's POWER Account in order to reflect the new balance.
- b. The card may be used by enrollees only to pay for covered services performed by network providers.
- c. For covered services provided out-of-network, if the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's card, the MCO or ESP will reimburse the out-of-network provider with funds from the enrollee's POWER Account. ESP and the MCOs may also reimburse in network providers with funds from the enrollee's POWER Account if the network providers lack the capacity to conduct the transaction using the enrollee's card.
- d. The MCOs and ESP are required to have an internal system of safeguards for the cards and to manage the POWER Accounts. The state will actively monitor plans and their management of the POWER Accounts either through a separate annual audit or will require the plans to fund annual independent audits.

42. **Use of POWER Account Funds.** Each enrollee will be responsible for the use of funds in

his or her POWER Account until the deductible is met. However, POWER Account funds can only be used by the enrollee to pay for the MCO's covered services, including any enhanced services the MCO may choose to offer.

- a. **Out of Network Providers.** In spending POWER Account funds, enrollees will be permitted to pay for the following covered services, even if obtained through out-of-network providers:
  - i. Family planning services;
  - ii. Emergency medical services, subject to the prudent layperson standard of an "emergency medical condition," as specified in 42 CFR 438.114;
  - iii. Medically necessary covered services, if the MCO's network is unable to provide the service within a 30-mile radius for primary care and a 60-mile radius for specialty care of the enrollee's residence; and
  - iv. Nurse practitioner services.
- b. **Payment for Out of Network Providers.** For the out-of-network services specified in subparagraph (a), the MCO must coordinate with the out-of-network provider to ensure that the cost to the enrollee is no greater than it would be if the services were provided in-network. If the out-of-network provider lacks the capacity to conduct the transaction using the enrollee's POWER card, the provider must be instructed to bill the MCO and the MCO must reimburse the out-of-network provider with funds from the enrollee's POWER Account.
- c. **Carry-Forward and Use of Excess Funds.** At the end of a 12-month coverage term, there may be funds remaining in an enrollee's POWER Account. Some or all of the funds remaining in an enrollee's POWER Account may be carried forward to the next coverage term to reduce the enrollee's required POWER Account contribution in that coverage term. The amount of leftover funds available to be carried forward will depend on several factors outlined below.
  - i. If the enrollee has obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, the entire remaining POWER Account balance, including monies contributed by the state, will be carried forward. The enrollee's required contribution for the new year will be the amount determined using the state's algorithm (paragraph 35 (b)), reduced by the amount carried forward. If the amount carried forward is greater than the amount determined using the state's algorithm, the required contribution for the new coverage year is \$0. For non-ESP enrollees, the state must then contribute to the POWER Account an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and \$1,100.

- ii. If the enrollee has not obtained all the recommended preventive care services, as advised in writing, appropriate for the enrollee's age, gender, and medical condition, only the pro rata share of the enrollee's portion of the POWER Account balance may be carried forward. The pro rata share of the enrollee's portion equals the amount the enrollee's required contribution for the expiring coverage term, plus any enrollee balances rolled over from previous coverage terms, multiplied by the unspent percentage of the POWER Account from the expiring term. The state's portion of the unspent POWER Account balance, calculated similarly to the enrollee's portion of the unspent POWER Account balance, must be returned by the HIP MCO to the state. The enrollee's POWER Account contribution for the next coverage term is the amount determined using the state's algorithm (paragraph 37(b)), minus the amount carried forward as calculated above. The state must contribute an amount equal to the difference between the sum of the rollover amount and the enrollee's (reduced) annual POWER Account contribution, and \$1,100. The state may collapse the recovery of the state share of the POWER Account balance and its contribution for the next coverage term into a single, net transaction.
- iii. If the amount of funds available to be carried is in excess of the enrollee's required POWER Account contribution for the next coverage term, the excess amount will be credited to the state to reduce the state's contribution in the next coverage term. This shall occur regardless of whether or not the enrollee obtained his or her recommended preventive care services.
- iv. The HIP MCOs and ESP must develop and maintain accounting systems capable of tracking POWER Account balances and sub-balances according to whether they were initially contributed by the enrollee or the state. POWER Account balances must maintain their identity as enrollee or state contributions throughout the process.

**43. Non-Payment of Monthly POWER Account Contribution.** If an enrollee does not make a required monthly contribution within 60 days of its due date, the enrollee will be terminated from participation in HIP and disenrolled from the MCO or ESP. The enrollee will also forfeit 25 percent of the enrollee's pro rata share of funds remaining in the POWER account.

- a. Before terminating the enrollee, the MCO or ESP must provide at least one written notice advising the enrollee of the delinquent payment, and the date by which the contribution must be paid to prevent disenrollment, as well as notice of the enrollee's appeal rights. The notice must be sent to the enrollee on or before the seventh day of delinquency and must state that the enrollee will be disenrolled from the MCO or ESP and terminated from participation in HIP if payment is not received prior to the date specified in the notice. The notice must explain that if the enrollee is terminated from participation in HIP, the enrollee will not be able to reapply for HIP coverage for a period of at least 12 months.
- b. The MCO or ESP is required to refund the enrollee's pro rata portion of the POWER Account, which must be distributed to the enrollee no later than sixty (60) days after the

last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as follows:

- i. Calculate the total enrollee contribution to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms ( $E^T$ );
- ii. Calculate the amount actually contributed by the enrollee to the POWER Account for the coverage term, including all enrollee balances carried forward from prior coverage terms ( $E^A$ );
- iii. Calculate the percentage of the POWER Account expended during the coverage term, which will equal the total dollar amount expended, divided by \$1,100 (u);
- iv. Multiply the result in (iii) by the result in (i), and subtract from the result in (ii) ( $R = E^A - u * E^T$ ).
- v. If the result in (iv) is positive, the MCO or ESP must return 75 percent of this amount to the enrollee and 25 percent of this amount to the state.
- vi. If the result in (iv) is negative, the result is the amount that the enrollee owes to the MCO or ESP as described in paragraphs 38 (b) through 38(d).
- vii. The MCO or ESP must return to the state all unexpended state POWER Account contributions, including amounts carried forward from prior coverage terms.

**44. Loss of Eligibility for HIP and POWER Account Contributions.** If an enrollee becomes ineligible for HIP, either at redetermination or at another time, the MCO or ESP must refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO or ESP. The amount payable to the enrollee shall be determined as in paragraph 43(b), except that in step (v), 100 percent of the result must be returned to the enrollee.

**45. Failure to Redetermine Eligibility and POWER Account Contributions.** If an enrollee fails to complete all necessary steps to maintain eligibility for HIP at the end of a coverage term, the enrollee will not be permitted to reapply for HIP for a period of at least 12 months.

The MCO or ESP will be required to refund the enrollee's pro rata share of his or her POWER Account balance, if any, within 60 days of the enrollee's last date of participation in the MCO. The amount payable to the enrollee shall be determined using the calculations specified in paragraphs 43 and 44. Unspent state POWER Account contributions must be returned to the state.

**46. POWER Account Balance Transfers.** If an enrollee transfers to a new MCO or ESP, the enrollee's POWER Account balance will be transferred to the state within thirty (30) days from the date the MCO or ESP was notified by the state.

For a transfer at the end of a coverage term, the current MCO or ESP remains responsible for determining the amount of the enrollee's POWER Account that may be carried over, and forwarding that amount to the state. The state will forward the balance to the new MCO or ESP.

47. **POWER Account Reporting to State.** Each MCO and ESP must submit a report to the state each month that provides the following for each terminated or ineligible enrollee:

- a. Demographic information on the enrollee;
- b. The balance remaining in the enrollee's POWER account;
- c. The amount paid to the enrollee as required under paragraphs 42 through 45; and
- d. The amount to be returned to the state.

## VII. GENERAL REPORTING REQUIREMENTS

48. **General Financial Requirements.** The state shall comply with all general financial requirements under title XIX set forth in these STCs.

49. **Reporting Requirements Relating to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in this agreement. The state must submit any corrected budget and/or allotment neutrality data upon request.

50. **Compliance With Managed Care Reporting Requirements.** The state shall comply with all managed care reporting regulations at 42 CFR Part 438 *et seq.*, except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

51. **Monthly Calls.** CMS will schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost-sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting related to budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

52. **Quarterly Progress Reports:** The state must submit progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter (March, June, September, and December of each year). The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: approval and contracting with new plans, benefits, enrollment and disenrollment, grievances, quality of care, access, health plan contract compliance and financial performance that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. Action plans for addressing any policy, administrative, or budget issues identified;
- d. Quarterly enrollment reports for demonstration eligibles that include the member months for each demonstration population, as required to evaluate compliance with the budget neutrality agreement, and as specified in Section VIII, paragraph 57; and other statistical reports listed in Attachment A; and
- e. Evaluation activities and interim findings including the number of individuals who are within \$100,000 of reaching the annual or lifetime benefit limit. The state shall report on its efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.
- f. A report on which option the state is currently using and any plans to change the option regarding state contributions to ESP enrollees' POWER Accounts as outlined in paragraph 25(b).
- g. A list of services (including service codes) that are considered to be preventive services that can be provided from the \$500 of "first dollar coverage," and a definition of the preventive services that enrollees must receive in order to qualify for the full carry-forward of POWER Account funds as outlined in paragraph 42(c).

### **53. Annual Report.**

- a. The state shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.
- b. In addition, the state shall include information on the following in its draft annual report:

- i. The level of preventive services compliance, including a summary of member compliance and non-compliance with Office of Medicaid Policy and Planning (OMPP) recommended preventive services.
  - ii. The number of HIP Caretakers and HIP Adults who are within \$100,000 of exceeding the annual and or lifetime benefit limit and the state's efforts to refer these individuals to the regular Medicaid program, M.E.D. Works, or ICHIA.
  - iii. The progress of Indiana's care management program for the Aged, Blind, and Disabled (ABD) population and the feasibility of moving part or all of the ABD population into managed care.
  - iv. Any strategies the state is examining to reduce the uninsurance rate in the state, such as restructuring the Small Group Reinsurance Pool to make it more attractive to small groups.
  - v. Incentive programs developed by HIP MCOs for providers and HIP members. Potential areas include emergency room utilization, access to care, asthma, obesity, preventive service utilization, and smoking cessation.
  - vi. A description of how health information technology (HIT) is progressing in the state and how the demonstration has assisted in progressing HIT, including any HIT and data sharing initiatives that are developed or implemented by HIP MCOs to improve quality, efficiency, and safety of health care delivery in Indiana.
  - vii. A description of the process through which a HIP member may appeal the state's decision to move the member out of an MCO to ESP or out of ESP to an MCO as outlined in paragraph 25(e).
  - viii. A description of the process for ensuring that families do not exceed the 5 percent cost sharing limit as outlined in paragraph 33(c).
  - ix. A description of the type of services that are being paid for by POWER Account contributions broken down by gender, age and income level.
- c. The state shall submit the draft annual report no later than 120 days after the end of each demonstration year (DY) for CMS review. The state shall finalize and submit the final draft report within 60 days from receipt of CMS' comments.

## VIII. GENERAL FINANCIAL REQUIREMENTS

54. **Quarterly Expenditure Reports.** The state must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the demonstration under section 1115 authority, which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section IX.
55. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality expenditure limit:

- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, Indiana must report demonstration expenditures through the MBES and state Children's Health Insurance Program Budget and Expenditure System (CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made. For this purpose, DY 1 is defined as the year beginning January 1, 2008, and ending December 31, 2008. DY 2 and subsequent DYs are defined accordingly. All title XIX service expenditures that are not demonstration expenditures and are not part of any other title XIX waiver program should be reported on Forms CMS-64.9 Base/64.9P Base. Expenditures for HHW Caretakers, HHW Children, and HHW Pregnant Women with dates of service December 31, 2007, and before, but with dates of payment January 1, 2008, and after, should be reported on Forms CMS-64.9 Base and 64.9P Base.
- b. **Reporting of HIP Plan Premiums and POWER Account Contributions** The state must report HIP plan premiums and POWER Account contributions as follows:
- i. HIP MCO Premiums. HIP plan premiums must be reported on Forms CMS-64.9 Waiver and CMS-64.9P Waiver, using Line 18A.
  - ii. State's Contributions to Participants' POWER Accounts. The state's contributions to participants' POWER Accounts must be reported on Forms CMS-64.9 Waiver, using Line 18E. (Because individual participants' POWER Account contributions are collected by the HIP plans, and are not subject to federal matching, they are not to be reported on the CMS-64.)
  - iii. Recouped State Contributions to Participants' POWER Accounts. In the event that the state recoups state POWER Account contributions from HIP MCOs (for example, when a participant disenrolls from HIP; see paragraphs 42.c.ii., 43.b.vii., 44, 45, and 46), the amounts collected must be reported as a prior period adjustment using Line 10B of the Forms CMS-64.9P Waiver on Line 18E.
  - iv. Forfeited Participant Contributions. In the event that a participant's eligibility for HIP is terminated for non-payment of POWER Account contributions, resulting in forfeiture of 25 percent of the remainder of the participant's share of their POWER Account balance (see paragraph 46(b)(v)), the state must recover the forfeited funds from the HIP MCO and must report the recovery as a collection on Form CMS-64, Line 9D. The state must also provide a supplementary report on the Narrative section of Form CMS-64, stating the amount reported on Line 9D attributable to the recovered participant POWER Account balances, along with a disaggregation of the amount reported by eligibility group, as specified in subparagraph (d).
  - v. Service Expenditures Through ESP. Expenditures for health care services provided through ESP other than those funded through state or enrollee POWER Account contributions, must be reported on CMS-64.9 Waiver and CMS-64.9P Waiver, by eligibility group, on the appropriate service line. In addition, expenditures for

administrative services provided through ESP must be reported on CMS-64.10 Waiver and CMS-64.10P Waiver, by the appropriate eligibility group—“ESP Caretakers Adm” or “ESP Adults Adm,” as described in subparagraph (g) below.

- c. **Cost Settlements.** For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlements not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the state Medicaid Manual.
- d. **Use of Waiver Forms.** The following five (5) waiver Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.
  - i. “HHW Caretakers” expenditures
  - ii. “HHW Children” expenditures
  - iii. “HHW Pregnant Women” expenditures
  - iv. “HIP Caretakers” expenditures
  - v. “HIP Adults” expenditures
- e. **Pharmacy Rebates.** The state may propose a methodology for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- f. **Title XIX Expenditures Subject to the Budget Neutrality Expenditure Limit.** For the purpose of this section, the term “expenditures subject to the budget neutrality expenditure limit” refers to all title XIX expenditures on behalf of individuals who are enrolled in this demonstration, as defined in Section IV, paragraph 16, including all service expenditures net of premium collections and other offsetting collections. All title XIX expenditures that are subject to the budget neutrality expenditure limit are

considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

- g. **Administrative Costs.** The following provisions govern reporting of administrative costs during the demonstration.
- i. In accordance to federal regulations at 42 CFR 488.812(b)(2), the portion of the state's payments to ESP that is for administrative services must be claimed by the state as an administrative cost at the federal matching rates available for the costs of administration of the Medicaid program. These administrative expenses are costs of the demonstration waiver that are subject to the budget neutrality expenditure limit described in section IX of these STCs. These administrative costs must be reported on Forms CMS-64.10 Waiver and/or 64.10P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY for which the administrative services were paid. Separate forms must be submitted, using the waiver name "ESP Caretakers Adm" to report expenses related to the management of HIP Caretakers' services, and "ESP Adults Adm" to report expenses related to the management of HIP Adults' services.
  - ii. Administrative costs attributable to the demonstration that are not described in (i) must be reported under waiver name "HIP." These expenses are not subject to the budget neutrality limit.
  - iii. Administrative costs not related to the demonstration should be reported on the appropriate CMS-64.10 Base or 64.10P Base, or another waiver schedule as appropriate, and not subject to the budget neutrality test for this demonstration.
- h. **Claiming Period.** All claims for expenditures subject to the budget neutrality expenditure limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately on the CMS-64 waiver forms the net expenditures related to dates of service during the operation of the section 1115 demonstration, in order to account for these expenditures properly to determine budget neutrality.
- i. **Mandated Increase in Physician Payment Rates in 2013.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013, with the federal government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of

separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date.

**56. Reporting Expenditure Reconciliation and Limitations.**

- a. The state must take corrective action to ensure that expenditures subject to the budget neutrality limit are reported in a manner that conforms to the requirements outlined in paragraph 55 of these STCs. Specifically, the state must submit prior period adjustments, using Form CMS 64.9P Waiver as needed, to ensure that net expenditures for health care coverage for the demonstration population are correctly reported by DY according to dates of service, which will be summarized on the C Report. This applies to expenditures for DY 1 through 5. The state must complete this action by March 31, 2013.
- b. **Time Frame and Limitations** – The state must complete the reconciliation process by March 31, 2013, and the corrections must be reported on the CMS-64 report for the quarter ending December 31, 2012. The state may not amend the demonstration as defined in paragraph 7 until the expenditure reconciliation process is complete.
- c. **Application of the Penalty.** The state will be required to reimburse the federal share of all demonstration related expenditures if the result of expenditure reconciliation process determines that the demonstration is not budget neutral during the prior approval period (DY 1 through DY 5).

**57. Reporting Member Months:** The following describes the reporting of member months for HIP:

- a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the quarterly report required under Section VII, paragraph 52, the actual number of eligible member months for all HIP eligibility groups defined in Section IV, paragraph 16. The state must submit a statement accompanying the quarterly report, certifying the accuracy of this information. Member months should be reported only for individuals who are participating in the demonstration, as defined in Section IV, paragraph 16.

A template for reporting member months in the quarterly progress reports is provided in Attachment A. Member months for “HHW Caretakers,” “HHW Children,” “HHW Pregnant Women,” and “HIP Caretakers” are reported in section 6A of the template, and are used in the calculation of the budget neutrality expenditure limit. Member months for “HIP Adults” are reported in section 6B of the template, and are not used to calculate the budget neutrality expenditure limit.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible

for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member months.

- c. "Eligible member months" does not include the number of months in which an individual participating in the demonstration cannot access services as a result of reaching the lifetime benefit limits outlined in Section VI, paragraph 34.

**58. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and state and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

**59. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the budget neutrality limits described in Section IX.

- a. Administrative costs, including those associated with the administration of the demonstration;
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan and waiver authorities;
- c. Net expenditures and prior period adjustments, made under approved Expenditure Authorities granted through section 1115(a)(2) of the Act, with dates of service during the operation of the demonstration.

**60. Sources of Non-Federal Share.** The state provides assurance that the matching non-federal share of funds for the demonstration is state/local monies. The state further assures that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
  - c. Under all circumstances, health care providers must retain 100 percent of the HIP reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.
  - d. FFP will not be available for individual contributions to the POWER Accounts. FFP will be available for state contributions to the POWER Accounts, payments to MCOs, and service expenditures through ESP. Payments to the MCOs are based on the assumption of a \$1,100 deductible.
61. **Monitoring the Demonstration.** The state shall provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable timeframe.

## **IX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**

62. **Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, and is determined by using a per capita cost method, with an aggregate adjustment for projected DSH payments. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the state using the procedures described in Section VIII, paragraph 55.
63. **Risk.** Indiana shall be at risk for the per capita cost (as determined by the method described below in this Section) for Medicaid eligibles in the following eligibility groups: “HHW Caretakers,” “HHW Children,” “HHW Pregnant Women,” and “HIP Caretakers,” but not for the number of demonstration eligibles in each of the groups. By providing FFP for HIP enrollees in these eligibility groups, Indiana shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Indiana at risk for the per capita costs for HIP enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration. Indiana will be at risk for both per capita costs and enrollment for “HIP Adults” eligibles.

64. **Budget Neutrality Annual Expenditure Limits.** For each DY, two annual limits are calculated.

- a. **Limit A.** Limit A consists of the sum of three components. Components one through three are calculated as the projected per member per month (PMPM) cost times the actual number of member months (reported by the state in accordance with paragraph 58) for “HHW Caretakers,” “HHW Children,” “HHW Pregnant Women,” each multiplied by the Composite federal Share (defined below). Component four equals three-quarters of Indiana’s federal share DSH allotment for the FFY that ends during the DY, minus \$113,387,550 (federal share). Component five equals one-quarter of Indiana’s federal share DSH allotment for the FFY that begins during the DY, minus \$37,795,850 (federal share). Components four and five are only applicable to DYs 1 – 5.
- b. **Limit B.** Limit B is calculated as the projected PMPM cost times the actual number of member months for “HIP Caretakers,” multiplied by the Composite federal Share.
- c. **PMPM Costs.** The following table gives the projected PMPM costs for the calculations described above by DY.

	<b>Trend</b>	<b>DY 1</b>	<b>DY 2</b>	<b>DY 3</b>	<b>DY 4</b>	<b>DY 5</b>	<b>Trend</b>	<b>DY 6</b>
<b>HHW Caretakers</b>	4.40%	\$328.07	\$342.50	\$357.57	\$373.30	\$389.73	4.40%	\$406.88
<b>HHW Children</b>	4.40%	\$180.51	\$188.45	\$196.74	\$205.40	\$214.44	4.40%	\$223.88
<b>HHW Pregnant Women</b>	4.40%	\$476.17	\$497.12	\$519.00	\$541.83	\$565.67	4.40%	\$590.56
<b>HIP Caretakers</b>	4.40%	\$312.59	\$326.34	\$340.70	\$355.69	\$371.34	4.40%	\$387.68

- d. **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the 5-year approval period, as reported on the forms listed in paragraph 55(d), by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the 5-year approval period (see paragraphs 9, 10, and 12), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be used.

65. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under HIP.

**66. Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, by combining the annual limits calculated following paragraph 64 into lifetime limits for the demonstration. The following describes how budget neutrality will be enforced.

- a. Test A consists of application of the combined annual Limits A to demonstration spending reported on the following schedules, as defined in paragraph 55(d) and 55(f): “HHW Caretakers,” “HHW Children,” “HHW Pregnant Women,” “HIP Adults,” “ESP Adults Adm.”
- b. Test B consists of application of the combined annual Limits B to demonstration spending reported on the “HIP Caretakers” and “ESP Caretakers Adm” schedule.
- c. If Test A expenditures exceed Limit A, the state must refund excess expenditures from Test A to CMS. Test B savings cannot be used to offset excess expenditures from Test A.
- d. If Test B expenditures exceed Limit B and Test A shows savings, a second test is performed by combining Tests A and B. The state must refund excess expenditures (if any) from the combined test to CMS.
- e. If both Tests A and B show excess expenditures, the state must refund the excess expenditures from both tests to CMS.
- f. If the demonstration is terminated prior to the end of the budget neutrality agreement, an assessment of the state’s compliance with these requirements shall be based on the time elapsed through the termination date.
- g. **Interim Checks/Corrective Action Plan.** If the state exceeds the calculated cumulative target limit for both Tests A and B combined by the percentage identified below for any of the DYs, the state shall submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 1	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 2	Cumulative budget neutrality expenditure cap plus:	1 percent
Year 3	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 4	Cumulative budget neutrality expenditure cap plus:	0.5 percent
Year 5	Cumulative budget neutrality expenditure cap plus:	0 percent
Year 6	Cumulative budget neutrality expenditure cap plus:	0 percent

**X. EVALUATION OF THE DEMONSTRATION**

**67. Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after the effective date of the demonstration. At a minimum, the draft design must

include a discussion of the goals and objectives set forth in Section II of these STCs, as well as the specific hypotheses that are being tested. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state shall ensure that the draft evaluation design will address the following evaluation questions:

1. How many HIP participants reach their \$300,000 annual benefit limit each year? How do these individuals meet their health care needs during the period of exhaustion of their benefit and the beginning of the next coverage term?
2. How many HIP participants reach their \$1,000,000 lifetime benefit maximum? How do they go about meeting their health care needs after their HIP benefits are exhausted?
3. What are the consequences of limiting participants' ability to switch plans after they have made an initial POWER Account contribution? What percentage of HIP applicants are auto-assigned to an MCO?
4. How many enrollees are reassigned from HIP MCOs each year to ESP? How many are reassigned from ESP to a HIP MCO?
5. What percentage of the potentially eligible population enrolls in HIP? How does the percentage vary by major population subgroups (HIP Caretakers, HIP Adults) and income level?
6. What are the consequences of requiring HIP participants with family income less than 150 percent of the FPL to pay monthly premiums? How many of these participants fail to make their first POWER Account contribution? How many of these participants are disenrolled for failure to pay their premiums?
7. To what extent has HIP impacted the uninsurance rate in Indiana?
8. To what extent has HIP reduced uncompensated care provided by Indiana's federally funded health clinics?
9. How many enrollees exhaust their POWER Account each year? How many enrollees are able to roll-over a sufficient POWER Account balance to reduce their subsequent year's required contribution by at least half? How many enrollees are able to achieve a \$0 contribution by this means?

**68. Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

**69. Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the state shall submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The

state must submit to CMS a draft of the evaluation report within 120 days after expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

70. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the m shall cooperate fully with CMS or the independent evaluator selected by CMS. The state shall submit the required data to CMS or the contractor.

**XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION**

<b>Date – Specific</b>	<b>Deliverable</b>	<b>STC Reference</b>
3/31/2013	Reporting Expenditure Reconciliation Action	Section VIII, paragraph 56
6/30/2013	Submit Demonstration Extension Request	Section II, paragraph 8
6/30/2013	Submit Interim Evaluation Report	Section X, paragraph 68

	<b>Deliverable</b>	<b>STC Reference</b>
<b>Annual</b>	By May 1st - Draft Annual Report	Section VII, paragraph 53
<b>Quarterly</b>		
	Quarterly Progress Reports	Section VII, paragraph 52
	Quarterly Expenditure Reports	Section VIII, paragraph 54
	Eligible Member Months	Section VIII, paragraph 57

Under Section VII, paragraph 52 of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

### **NARRATIVE REPORT FORMAT:**

**Title Line One – Healthy Indiana Plan Demonstration**

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:

Demonstration Year: 1 (1/01/08 - 12/31/08)

Federal Fiscal Quarter: 2/2008 (1/08 - 3/08)

### **Introduction:**

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

### **Eligibility and Enrollment Information:**

Please provide the following information. If there was no activity under a particular facet of the tables below, the state should indicate that by “0.”

1. The number of HIP members who have reached \$200,000 in benefits in a year or \$900,000 in benefits in a lifetime. Of these individuals, how many have been referred to the regular Medicaid program, Medicaid for Employees with Disabilities (M.E.D. Works), or ICHIA, the state’s high-risk pool.
2. The number of HIP members who have reached the \$300,000 annual and \$1 million lifetime benefit limits during the quarter. Of these individuals, how many were determined eligible for the regular Medicaid program, and thus have continued coverage available despite having reached their coverage limit? Of these individuals who were not determined eligible for regular Medicaid, how many were determined eligible for M.E.D. Works, and how many were determined eligible for ESP?
3. The number of HIP enrollees who are receiving benefits through ESP.
4. Report on the number of HIP applicants and the disposition of their applications, by income relative to FPL, using the following table:

<b>FPL Level</b>	<b>Column A: Number of Hoosier Healthwise or HIP Applicants</b>	<b>Column B: Number enrolled in the Hoosier Healthwise program</b>	<b>Column C: Number enrolled with a HIP MCO</b>	<b>Column D: Number enrolled in ESP</b>	<b>Column E: Number of enrollees who failed to make POWER Account contribution and were terminated.</b>	<b>Column F: Number of applications declined due to a finding of ESI access or health insurance in the last 6 months</b>
0-22% FPL						
22-50% FPL						
50-100% FPL						
100-150% FPL						
150-200% FPL						

5. Report on HIP enrollment numbers using the following table:

<b>FPL Level</b>	<b>Column A: Number of persons enrolled at start of quarter</b>	<b>Column B: Number of persons enrolled during quarter</b>	<b>Column C: Number of persons disenrolled for non-payment of POWER Account</b>	<b>Column D: Number of persons disenrolled at end of coverage term for failure to recertify</b>	<b>Column E: Number of persons disenrolled for other reasons</b>	<b>Column F: Number of persons enrolled in HIP at the end of the quarter (F)=(A)+(B)-(C)-(D)-(E)</b>
<b>0-22% FPL</b>						
<b>22-50% FPL</b>						
<b>50-100% FPL</b>						
<b>100-150% FPL</b>						
<b>150-200% FPL</b>						

6. Report member-months for budget neutrality:

**A. For Use in Budget Neutrality Calculations**

<b>Eligibility Group</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Total for Quarter Ending XX/XX</b>
<b>HHW Caretakers</b>				
<b>HHW Children</b>				
<b>HHW Pregnant Women</b>				
<b>HIP Caretakers</b>				

**B. Not Used in Budget Neutrality Calculations**

<b>Eligibility Group</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Total for Quarter Ending XX/XX</b>
<b>HIP Adults</b>				

**Outreach/Innovative Activities:**

Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues:**

Identify all significant program developments/issues/problems that have occurred in the current quarter, including, but not limited to, approval and contracting with new plans, benefit changes, and legislative activity.

**Financial/Budget Neutrality Developments/Issues:**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

**Consumer Issues:**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

**Quality Assurance/Monitoring Activity:**

Identify any quality assurance/monitoring activity in current quarter.

**Demonstration Evaluation**

Discuss progress of evaluation design and planning.

**Enclosures/Attachments:**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s):**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS:**